Will my Living Will be honored by emergency medical personnel, in the ambulance or emergency room?

Sometimes people who have signed Living Wills are surprised and upset when emergency medical personnel disregard the Living Will and administer life-support anyway. The reason that this may happen is that, in an emergency, the staff may not have time to read the Living Will to make sure that the patient is in a terminal condition and that it is indeed appropriate to withdraw treatment. If you are already in a terminal condition and feel strongly that you do not want to be given life-support under any circumstances, you should talk to your doctor. Your doctor may be able to notify the ambulance service and the emergency room that they should not give life-support and that they should only give you treatment that will ease your pain and keep you comfortable.

Will my Living will, executed in Maine, be honored in another state?

It is possible that you may get sick, injured, or have to go to a hospital while visiting in another state. You should carry a copy of your Living Will with you in your wallet or purse, since your medical record will not be available right away to the doctors there. You should also have your Living Will witnessed by a notary public or attorney if you travel sometimes and are concerned about how

TN-92-01

Approval date MAR 12 1992 Effective date DEC 01

your Living Will will be treated in another state. Whether the doctors there follow your directions depends on whether that state has a Living Will law similar to Maine's. As of October 1991, at least 41 states recognized Living Wills.

Will signing a Living Will affect my insurance?

The law says that insurance companies may not base anything in an existing or future life insurance policy on whether a person does or does not have a Living Will.

TN-92-01

Approval date MAR 12 1992 Effective date DEC 01 1992

NON-DISCRIMINATION NOTICE

In accordance with Title VI if the Civil Rights Act of 1964(42 U.S.C.§2000d et seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), the Age Discrimination Act of 1975, as amended (42 U.S.C. §6101 et seq.), and Title IX of the Education Amendments of 1972, the Maine Department of Human Services does not discriminate on the basis of sex, race, color, national origin, handicap or age in admission or access to treatment or employment in its programs or activities. Ann Twombly, Affirmative Action Officer, has been designated to coordinate our efforts to comply with the U.S. Department of Education (34 C.F.R. Part 106) implementing these Federal laws. Inquiries concerning the application of these regulations and our grievance procedures for resolution of complaints alleging discrimination may be referred to Ann Twombly at 221 State Street, Augusta, Maine 04333. Telephone number: (207)289-3488(Voice) or 1-800-332-1003(TTY), or to the Assistant Secretary of the Office of Civil Rights, Washington, D.C.

Funding for this publication was made available through the
Maine Department of Human Services
Bureau of Elder and Adult Services
Appropriation # 010-10A-6006-012

TN - 92-01

Approval date MAR 1 2 1992

Effective date DEC 0 1 1

"ALLET CARD

f you do decide to sign any of the forms in this packet, be sure also to fill out this card and keep it in your wallet. By doing so, you will make it easier for the doctor to locate your living will or durable power of attorney, especially if you get sick or injured while traveling.

__ I have a Living Will. __ I have a Durable Health Care Power of Attorney The signed originals of these documents are located at: _____ _____ _____ _____ In case of emergency please contact: _____ Name _____ Address _____ City,State,Zip _____ Phone	ADVANCE DIRECTIVE INFORMATION CARD _____ Name _____ Address _____ City _____ State, Zip _____ Signature Please see reverse side for important information

Cut out this card, fold in half and keep in your wallet.

TN - 92 - 01

Approval date MAR 1 2 1992 Effective date DEC 0 1 1992

DEFINITIONS

Maine law (18-A MRSA §5-701) contains the following definitions of words used in this Living Will declaration.

"Life-Sustaining Treatment" means any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying. "Life-sustaining treatment" may include artificially administered nutrition and hydration, which is the provision of nutrients and liquids through the use of tubes, intravenous procedures or similar medical interventions.

"Terminal Condition" means an incurable and irreversible condition that, without the administration of life-sustaining treatment will, in the opinion of the attending physician, result in death within a relatively short time.

"Persistent Vegetative State" means a state that occurs after coma in which the individual totally lacks higher cortical and cognitive function, but maintains vegetative brainstem processes, with no realistic possibility of recovery, as diagnosed in accordance with accepted medical standards. Vegetative brainstem processes may include one or more of the following: cycles of sleeping and waking, spontaneous eye opening and movements, some motor activity, vocalization, blood pressure, respiration and heart beat.

TN-92-01

Approval date MAR 12 1992 Effective date DEC 01 19..

LIVING WILL DECLARATION

My name is _____ and my address is _____. If I am determined by my attending physician to be in a terminal condition or a persistent vegetative state, and I am no longer able to make or communicate decisions regarding my medical treatment, then I direct my attending physician to withhold or withdraw all life-sustaining treatment that is not necessary for my comfort or to alleviate pain; and if there is any conflict at that time between this document and any other document I may have signed previously, then this document shall control.

_____ _____

My Signature Date

_____

My Social Security Number
or Date of Birth

OPTIONAL: If I am in a terminal condition or a persistent vegetative state, I want to receive nutrients and liquids provided through the use of tubes, intravenous procedures or similar medical interventions, even though other life-sustaining treatment is withheld or withdrawn.

_____

My Signature

NOTE: This optional provision must be signed to be effective. Otherwise, artificially administered nutrition and hydration may be withheld or withdrawn.

WITNESSES' SIGNATURES

The above-named _____, in my presence, voluntarily signed this writing or directed another to sign this writing on his/her behalf.

Witness: _____
Address: _____
_____

Witness: _____
Address: _____
_____

Approval date MAR 12 1992 Effective date DEC 01 1992

TN-92-11

SIGNATURE OF NOTARY PUBLIC

STATE OF MAINE
COUNTY OF _____,SS. _____,_____

Personally appeared the above-named_____ and acknowledged the foregoing Living Will Declaration to be his/her free act and deed.

Before me,

_____
Notary Public/Attorney-at-Law

NOTE: Maine does not require that Living Wills be notarized, but other states do. If you plan to travel to other states, it is suggested that you have this document notarized.

DELIVERY TO PHYSICIAN OR HEALTH CARE PROVIDER

You must give a copy of this document to your physician or other health care provider to make sure your wishes are followed. List here the names and addresses of those to whom copies will be given:

	NAME	ADDRESS
1.	_____	_____
2.	_____	_____
3.	_____	_____

Approval date MAR 1 2 1992 Effective date DEC 0 1 19

TN-92-01

THIS DOCUMENT MAY BE REVOKED AT ANY TIME

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

My name is _____ and my address is _____.
I hereby appoint the following person as my agent to make health care decisions for me if and when I am unable to make my own health care decisions: _____, whose address is _____ and whose phone number is _____.

Optional: if the person named as my agent is not available or is unable to act as my agent, then I appoint _____, whose address is _____ and whose phone number is _____.

In signing this document, I give my agent the power to make any health care decision which I myself would have the power to make, were I competent to do so. My agent has the power to consent to giving, withholding or stopping any health care, treatment, service, or diagnostic procedure. My agent also has the authority to talk with health care personnel, to get information, to look at my health care records, and to sign forms necessary to carry out health care decisions.

Optional: I give the following instructions concerning my health care:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Approval date MAR 12 1992 Effective date DEC 01 1992

By this document I intend to create a Durable Power of Attorney for Health Care which shall take effect upon my incapacity to make my own health care decisions and shall continue during that incapacity.

By signing here I indicate that I understand the purpose and effect of this document.

_____ _____
My Signature Date

_____
My Date of Birth or Social Security Number

WITNESSES' SIGNATURES

The above named _____ in my presence, voluntarily signed this document or directed that another sign this document on his/her behalf.

Witness: _____ Witness: _____
Address: _____ Address: _____
_____ _____

SIGNATURE OF NOTARY PUBLIC

STATE OF MAINE,
COUNTY OF _____, SS. _____, _____

Personally appeared the above-named _____ and acknowledged the foregoing Durable Power of Attorney for Health Care to be his/her free act and deed.

Before me,

_____
Attorney at Law/Notary Public

DELIVERY TO PHYSICIAN OR HEALTH CARE PROVIDER

You must give a copy of this document to your physician or other health care provider to make sure your wishes are followed. List here the names and addresses of those to whom copies will be given:

	NAME	ADDRESS
1.	_____	_____
2.	_____	_____
3.	_____	_____

Approval date MAR 1 4 1992 Effective date DEC 0 1 1992

THIS DOCUMENT MAY BE REVOKED AT ANY TIME

TN-92-01